

MAIL TO

STATE OF MARYLAND  
DEPARTMENT OF HEALTH & MENTAL HYGIENE  
DIVISION OF VITAL RECORDS  
P. O. BOX 13146  
BALTIMORE, MARYLAND 21203

SEND CHECK OR POSTAL MONEY ORDER  
PAYABLE TO  
DEPARTMENT OF HEALTH & MENTAL HYGIENE

Photocopies Issued

Date Issued

Remarks:

APR 16 D - 003810\*\*\*\*\*9.00

DO NOT WRITE IN THE ABOVE SPACE

APPLICATION FOR CERTIFIED COPY OF DEATH CERTIFICATE

The fee for Each Copy of a Death Certificate is \$3.00. If the record is not found, there is a \$3.00 fee for the search. -- Please do not send cash or stamps.

Date April 6 1987

Name of deceased

ROBERT

(First)

LEE

(Middle)

BOWER

(Last)

Date of death

December

(Month)

22

(Day)

1958

(Year)

Place of death regardless of residence

GOLDSBORO

(Town)

CAROLINE

(County)

MARYLAND

(State)

Number of copies desired

3

For what purpose desired

SETTLE AN ESTATE OF NIECE  
(MY COUSIN)

Your Name

GEORGE L. BOWER

Your Address

4525

ROSEDALE

AVENUE

(No.)

(Street)

BETHESDA

(City or town)

Maryland

(State)

20814-9998

(Zip Code)

\*\*\*\*\*3000 - 01-01-01

13540

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Goldsboro</b>		c. LENGTH OF STAY IN 1b <b>4 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Lee Bower</b>		4. DATE OF DEATH Month <b>12</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/1903</b>
9. AGE (In years, top, by day) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Lee Bower</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Day</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>231-16-3815</b>	
17. INFORMANT <b>Eva Bower</b>		Address <b>Goldsboro, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>3 yrs.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dawson O. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dawson O. George</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/26/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Scottsville, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13532

13541

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. LENGTH OF STAY IN 1b <u>5yrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Burton</u> Last <u>Dike, Jr.</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>14</u> Year <u>19 58</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Mar. 13, 1914</u>		9. AGE (In years last birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>entertainment</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jas. B. Dike, Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Bessie M. Lucas</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Jas. B. Dike, Jr., Denton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		ACTUAL SIGNATURE <u>Dawson T. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dawson T. George</u>		DATE SIGNED <u>12-16-58</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 16, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	
22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles V. Brown</u>		ADDRESS <u>Denton, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

MEDICAL CERTIFICATION

2

THE ALABAMA STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS - CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Examiner	
10. Signature of Physician		11. Signature of Coroner		12. Signature of Registrar	
13. Signature of Medical Examiner		14. Signature of Assistant Medical Examiner		15. Signature of Nurse	
16. Signature of Pathologist		17. Signature of Anatomist		18. Signature of Radiologist	
19. Signature of Toxicologist		20. Signature of Microscopist		21. Signature of Bacteriologist	
22. Signature of Chemist		23. Signature of Biologist		24. Signature of Zoologist	
25. Signature of Botanist		26. Signature of Geologist		27. Signature of Astronomer	
28. Signature of Meteorologist		29. Signature of Physicist		30. Signature of Mathematician	
31. Signature of Engineer		32. Signature of Architect		33. Signature of Lawyer	
34. Signature of Judge		35. Signature of Minister		36. Signature of Teacher	
37. Signature of Student		38. Signature of Worker		39. Signature of Farmer	
40. Signature of Merchant		41. Signature of Soldier		42. Signature of Sailor	
43. Signature of Pilot		44. Signature of Doctor		45. Signature of Nurse	
46. Signature of Pharmacist		47. Signature of Dentist		48. Signature of Veterinarian	
49. Signature of Engineer		50. Signature of Architect		51. Signature of Lawyer	
52. Signature of Judge		53. Signature of Minister		54. Signature of Teacher	
55. Signature of Student		56. Signature of Worker		57. Signature of Farmer	
58. Signature of Merchant		59. Signature of Soldier		60. Signature of Sailor	
61. Signature of Pilot		62. Signature of Doctor		63. Signature of Nurse	
64. Signature of Pharmacist		65. Signature of Dentist		66. Signature of Veterinarian	
67. Signature of Engineer		68. Signature of Architect		69. Signature of Lawyer	
70. Signature of Judge		71. Signature of Minister		72. Signature of Teacher	
73. Signature of Student		74. Signature of Worker		75. Signature of Farmer	
76. Signature of Merchant		77. Signature of Soldier		78. Signature of Sailor	
79. Signature of Pilot		80. Signature of Doctor		81. Signature of Nurse	
82. Signature of Pharmacist		83. Signature of Dentist		84. Signature of Veterinarian	
85. Signature of Engineer		86. Signature of Architect		87. Signature of Lawyer	
88. Signature of Judge		89. Signature of Minister		90. Signature of Teacher	
91. Signature of Student		92. Signature of Worker		93. Signature of Farmer	
94. Signature of Merchant		95. Signature of Soldier		96. Signature of Sailor	
97. Signature of Pilot		98. Signature of Doctor		99. Signature of Nurse	
100. Signature of Pharmacist		101. Signature of Dentist		102. Signature of Veterinarian	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13542

CERTIFICATE OF DEATH

13533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>				c. LENGTH OF STAY IN 1b <b>1 Mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Riverside Convelesent Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Hall</b> <b>142-2</b>			
d. NAME OF DECEASED (Type or print) <b>James Elmore</b>				d. STREET ADDRESS <b>Piney Neck</b>			
3. NAME OF DECEASED (Type or print) <b>James Elmore</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10 1881</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James R. Elmore</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>William Miller</b> Address <b>Rock Hall Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Artero Sclerosis</b> DUE TO (c) <b>2 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>12-1</b> 19 <b>58</b> , to <b>12-27</b> 19 <b>58</b> , that I last saw the deceased alive on <b>12-27</b> 19 <b>58</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Denton Md</b> DATE SIGNED <b>12-30-58</b>							
ACTUAL SIGNATURE <b>Dawson O. George</b> M.D. <b>Denton Md</b>				PHYSICIAN'S NAME (Type) <b>Dawson O. George</b> <b>Denton, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 29/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fairlee, Kent Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin V. Williams</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 13543 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>		c. LENGTH OF STAY IN 1b <b>15 Yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Greensboro</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>	
d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth F. Meyers</b>		4. DATE OF DEATH Month Day Year <b>12 31 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/10/1881</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Gustav Eversmyere</b>	
14. MOTHER'S MAIDEN NAME <b>No Record</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William G. Meyers Greensboro, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Ischemic Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Valvular Regurgitation Defect</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 30</b> , 1958, to <b>Dec. 31</b> , 1958, that I last saw the deceased alive on <b>Dec. 30</b> , 1958, and that death occurred at <b>12:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Stoner</b>		ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES H. STONER M.D.</b>		DATE SIGNED <b>Dec 31/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/3/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: [Faint text]

2. Sex: [Faint text]

3. Age: [Faint text]

4. Date of Birth: [Faint text]

5. Date of Death: [Faint text]

6. Place of Death: [Faint text]

7. Cause of Death: [Faint text]

8. Signature of Physician: [Faint text]

9. Signature of Registrar: [Faint text]

10. Date of Registration: [Faint text]

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
BOSTON, MASS.  
RECEIVED  
[Faint text]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13544

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13535

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u>		c. LENGTH OF STAY IN 1b <u>48 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>ORD KRESGIA RAIRIGH</u>			4. DATE OF DEATH Month Day Year <u>DEC 1, 1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 27, 1891</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food PRESERVING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>GEORGE S. RAIRIGH</u>		14. MOTHER'S MAIDEN NAME <u>MELINDA E. CREGG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Ord K. Rairigh, Ridgely, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Insufficiency.</u> (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 yrs -</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Ridgely</u>	(County) <u>Caroline</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Amos D. George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-3-58</u>	
NAME (Type) <u>Amos D. George</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) <u>Denton, Md.</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles D. George</u>		ADDRESS <u>Denton, Md.</u>	24a. REC'D BY REGISTRAR <u>DEC 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



13545

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Goldsboro</b>			
c. LENGTH OF STAY IN 1b <b>17 Yrs.</b>				d. STREET ADDRESS <b>None</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Corell</b> Middle <b>Harry</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>12</b> Day <b>31</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/22/1903</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Corell D. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Eunice Lafferty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-36-1844</b>		17. INFORMANT <b>Doris Thomas Goldsboro, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cecilia from Metastases General</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of Bronchogenic Carcinoma</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>JULY 24, 1958</b> , to <b>DEC. 31, 1958</b> , that I last saw the deceased alive on <b>DEC. 29, 1958</b> , and that death occurred at <b>2:45 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MAPLE AVE GREENSBORO, MD.</b> DATE SIGNED <b>JAN. 1, 1959</b>							
ACTUAL SIGNATURE <b>Robert H. Wright</b> M.D.				PHYSICIAN'S NAME (Type) <b>ROBERT H. WRIGHT, M.D. GREENSBORO, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>1/2/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Bouleais Greensboro, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1943

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1943

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>	
<p>4. Date of death</p>		<p>5. Time of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Manner of death</p>		<p>9. Signature of physician</p>	
<p>10. Signature of registrar</p>		<p>11. Signature of informant</p>		<p>12. Signature of witness</p>	
<p>13. Signature of funeral director</p>		<p>14. Signature of undertaker</p>		<p>15. Signature of cemetery</p>	
<p>16. Signature of health officer</p>		<p>17. Signature of coroner</p>		<p>18. Signature of jury</p>	
<p>19. Signature of medical examiner</p>		<p>20. Signature of pathologist</p>		<p>21. Signature of toxicologist</p>	
<p>22. Signature of bacteriologist</p>		<p>23. Signature of virologist</p>		<p>24. Signature of epidemiologist</p>	
<p>25. Signature of anthropologist</p>		<p>26. Signature of linguist</p>		<p>27. Signature of archaeologist</p>	
<p>28. Signature of geologist</p>		<p>29. Signature of meteorologist</p>		<p>30. Signature of astronomer</p>	
<p>31. Signature of physicist</p>		<p>32. Signature of chemist</p>		<p>33. Signature of biologist</p>	
<p>34. Signature of psychologist</p>		<p>35. Signature of sociologist</p>		<p>36. Signature of economist</p>	
<p>37. Signature of historian</p>		<p>38. Signature of geographer</p>		<p>39. Signature of political scientist</p>	
<p>40. Signature of law</p>		<p>41. Signature of education</p>		<p>42. Signature of business</p>	
<p>43. Signature of engineering</p>		<p>44. Signature of architecture</p>		<p>45. Signature of art</p>	
<p>46. Signature of music</p>		<p>47. Signature of theater</p>		<p>48. Signature of film</p>	
<p>49. Signature of television</p>		<p>50. Signature of radio</p>		<p>51. Signature of communication</p>	
<p>52. Signature of information</p>		<p>53. Signature of computer</p>		<p>54. Signature of mathematics</p>	
<p>55. Signature of statistics</p>		<p>56. Signature of logic</p>		<p>57. Signature of philosophy</p>	
<p>58. Signature of religion</p>		<p>59. Signature of ethics</p>		<p>60. Signature of aesthetics</p>	
<p>61. Signature of literature</p>		<p>62. Signature of history</p>		<p>63. Signature of science</p>	
<p>64. Signature of technology</p>		<p>65. Signature of industry</p>		<p>66. Signature of commerce</p>	
<p>67. Signature of agriculture</p>		<p>68. Signature of forestry</p>		<p>69. Signature of fishing</p>	
<p>70. Signature of hunting</p>		<p>71. Signature of sports</p>		<p>72. Signature of recreation</p>	
<p>73. Signature of travel</p>		<p>74. Signature of tourism</p>		<p>75. Signature of transportation</p>	
<p>76. Signature of infrastructure</p>		<p>77. Signature of utilities</p>		<p>78. Signature of energy</p>	
<p>79. Signature of environment</p>		<p>80. Signature of conservation</p>		<p>81. Signature of natural resources</p>	
<p>82. Signature of parks</p>		<p>83. Signature of recreation</p>		<p>84. Signature of culture</p>	
<p>85. Signature of arts</p>		<p>86. Signature of humanities</p>		<p>87. Signature of social sciences</p>	
<p>88. Signature of behavioral sciences</p>		<p>89. Signature of life sciences</p>		<p>90. Signature of physical sciences</p>	
<p>91. Signature of earth sciences</p>		<p>92. Signature of astronomy</p>		<p>93. Signature of cosmology</p>	
<p>94. Signature of astrophysics</p>		<p>95. Signature of particle physics</p>		<p>96. Signature of nuclear physics</p>	
<p>97. Signature of quantum mechanics</p>		<p>98. Signature of relativity</p>		<p>99. Signature of cosmology</p>	
<p>100. Signature of cosmology</p>		<p>101. Signature of cosmology</p>		<p>102. Signature of cosmology</p>	

## Reg. Dist. No.

MEDICAL CERTIFICATIONVS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

JOHN J. BROWN

JOHN J. BROWN

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